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Statement

Before the Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

Hearing on

Health Care Reform: Current Trends in Health Care Costs and Health Insurance Coverage

by

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Washington, D.C.

26 January 1993

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Statement Summary

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- Health insurance is a top priority for Americans. A recent EBRI/Gallup poll found that 68 percent of Americans regard health insurance as their most important employee benefit. Fifty-six percent said they would not accept a job that did not provide health benefits. Respondents said that their employer would have to pay them an average of $4,570 in additional income to forgo their current employer-provided health benefits.

- Several 1992 EBRI/Gallup surveys explored public attitudes toward policy options for health care reform. These surveys indicate a preference for employment-based insurance versus government provision. Forty-eight percent of respondents felt that employers should be most responsible for providing health benefits to full-time employees and their dependents rather than the federal government (31 percent) or individuals themselves (14 percent).

- More than 180 million persons under age 65—representing 83 percent of that population—were covered by either private or publicly financed health insurance in 1991. Although some of the nonelderly had public health insurance (15 percent), the most common source of coverage was private insurance—usually purchased through an employment-based plan. However, 16.6 percent of the nonelderly population—or 36.3 million people—received neither private health insurance nor publicly financed health coverage.

- Among the 36.3 million nonelderly Americans who did not have health insurance coverage in 1991, most were working adults (56.4 percent), while the remainder were children (26.3 percent) and nonworking adults (17.3 percent). The total number of uninsured under age 65 increased from 33.6 million in 1988 to 36.3 million in 1991.

- In 1991, 85 percent of the uninsured were working or living in a family headed by workers, primarily because most people live in families headed by workers. The majority of uninsured workers reported their industry of primary employment was retail trade, services, or manufacturing—industries that employ a majority of the work force. Workers most likely to be uninsured were either self-employed or working in agriculture, construction, retail sales, or services.

- Health insurance provision is a function of employer size. Nearly one-half of all uninsured workers were either self-employed or working in firms with fewer than 25 employees in 1991. Twenty-two percent of self-employed persons were uninsured, compared with 17 percent of all workers. Thirty-two percent of workers in firms with fewer than 10 employees were uninsured, compared with only 9 percent of workers in firms with 1,000 or more employees. In 1991, although only 27 percent of the nonelderly population lived in families whose head of household was self-employed or worked for a firm with fewer than 25 employees, this group accounted for 45 percent of the uninsured.

- The uninsured are concentrated disproportionately in low-income families. In 1991, 54 percent of the uninsured were in families with annual incomes under $20,000. While 34 percent of families with incomes of less than $5,000 were uninsured, only 11 percent of families with incomes of $20,000 or more were uninsured.

- Several policymakers have recently suggested limiting the exclusion of employer contributions to health insurance from workers' taxable income. Using the Tax Estimation and Analysis Model (TEAM), EBRI found that the imposition of a tax cap would be regressive in the sense that lower income filers would pay a larger percentage of their income than higher income filers toward the new tax.

- Requiring all employers to provide health benefits to workers and their dependents would decrease the number of uninsured from 36 million to 10 million, according to EBRI estimates. Because many of the uninsured work for small firms, exempting employers with fewer than 25 employees would only reduce the number of uninsured to about 25 million.

I am pleased to appear before you today to discuss current trends in health insurance coverage. My name is Dallas Salisbury. I am the president of the Employee Benefit Research Institute (EBRI), a nonprofit, nonpartisan, public policy research organization based in Washington, DC. EBRI has long been committed to the accurate statistical analysis of public policy benefits issues. Through our research, we strive to contribute to the formulation of effective and responsible health, welfare, and retirement policies. In keeping with EBRI's mission of providing objective and impartial analysis, our work does not contain recommendations.

◆ Introduction

The number of Americans without health insurance and with reduced access to health insurance represents a longstanding public policy issue. Many policymakers have sought to expand access by reforming the health care delivery system. This testimony provides information about public attitudes on health care, the current sources of health insurance in the United States, and the characteristics of the insured and uninsured to help in evaluating and estimating costs of health care reform proposals.

In addition, EBRI has estimated the impact of various reform proposals and examined how they would affect the coverage, costs, and quality of health care. This testimony examines the impact of limiting the tax exclusion for employer contributions to health insurance from workers' taxable income. It also examines the potential impact of employer mandates on the number of uninsured and on employment.

◆ Public Attitudes on Health Care

The public will be the arbiter of whether or not health reform initiatives are focused properly. To assess the shifting tides of public opinion, EBRI and The Gallup Organization, Inc. have conducted a monthly series of national public opinion polls on public attitudes toward economic security issues such as health insurance, health care satisfaction, and the value of benefits since June 1989. As elected officials well know, the tide of opinion can shift rapidly and a move from "what do you want?" to "what are you willing to pay?" can produce very different results.

Our surveys indicate that obtaining health insurance is a top priority for most Americans. A 1992 EBRI/Gallup poll found that 68 percent of Americans regard health insurance as their most important employee benefit, compared with 61 percent in 1990; 56 percent said they would not accept a job that did not provide health benefits. Respondents said that their employer would have to pay them an average of $4,570 in additional income to forgo their current employer-provided health benefits. This compares with $4,219 in 1990. Individuals prefer the hidden costs of lower wages over direct payments like premium co-payments.

Not only do Americans value the provision of insurance, the majority are satisfied with the health care they receive. However, they are not satisfied with the U.S. health care system as a whole. A 1992 EBRI/Gallup poll found that while more than 7 out of 10 Americans (73 percent) rate the U.S. health system as fair or poor (compared with 66 percent in 1990), most of those who indicated they had received care from a doctor or hospital in the past year rated the quality of that care as excellent or good (83 percent).

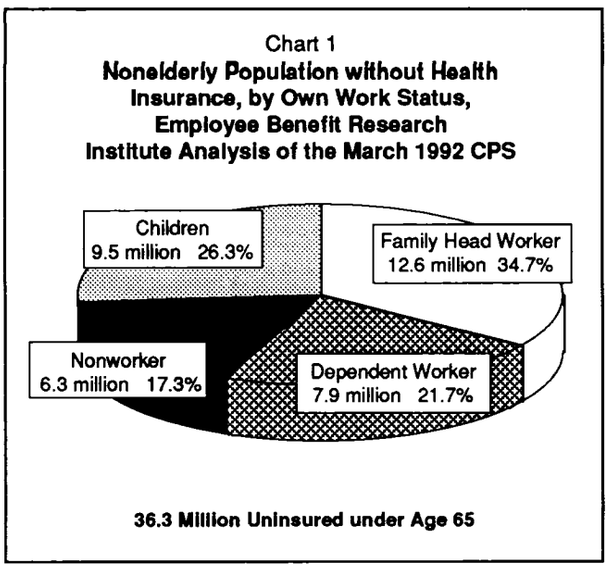
In response to a 1991 EBRI/Gallup survey, when asked what they liked most about the overall quality of the care they received from their physicians, respondents cited factors that are synonymous with higher cost such as attention and care (12 percent), friendliness (11 percent), and availability (10 percent). When asked what they liked least about their care, no single factor received special emphasis, but they were factors that generally reduce cost, including waiting time (8 percent); insufficient time spent by physician with patient (6 percent); and limited availability (4 percent). In addition to giving high ratings to their personal health care, respondents also expressed satisfaction with their health insurance benefits.

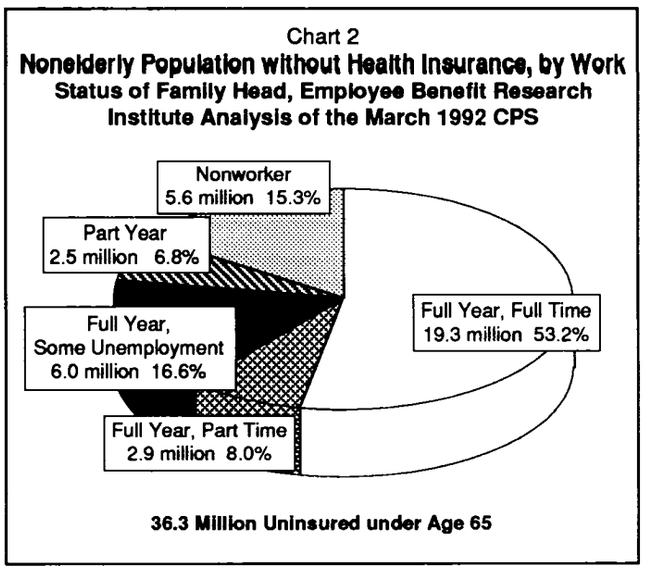
These findings suggest that the satisfaction that insured Americans feel for their health care may reduce their willingness to accept reform proposals that may alter or ration the care they receive.

Several 1992 EBRI/Gallup surveys explored public attitudes toward policy options for health care reform. These surveys indicate a preference for employment-based insurance versus government provision. Forty-eight percent of respondents felt that employers should be most responsible for providing health benefits to full-time employees and their dependents rather than the federal government (31 percent) or individuals themselves (14 percent).

While Americans tend to indicate a preference for an employment-based system, there continues to be support for other options for reform (such as government-sponsored national health insurance). However, while there is widespread support for various reform options, surveys indicate that most Americans have not yet come to terms with the various tradeoffs inherent in each option for reform—particularly with regard to cost.

For example, most analysts agree that access to health care cannot be increased without increasing costs or placing some limits on the care received. Yet, 77 percent of Americans said they believe everyone should receive the same amount and quality of health care, whether or not they can pay for the care, and 86 percent said they either disagree (47 percent) or strongly disagree (39 percent) that it would be acceptable to reduce the amount of health care available to the elderly in order to slow the rise in health care costs and increase access to health care for all Americans. In addition, a majority of Americans also disagreed or strongly disagreed with limiting the types of services public health programs will pay for low-income individuals (66 percent), the types of services health insurance plans will pay for (61 percent), and the introduction of new, more expensive high technology equipment that saves lives but may increase costs (57 percent). Despite this unwillingness to limit care, almost 8 out of 10 Americans (79 percent) indicated that the biggest problem in health care for society as a whole is cost.





◆ Access to Health Insurance

More than 180 million persons under age 65—representing 83 percent of that population—were covered by either private or publicly financed health insurance in 1991.[1] Although some of the nonelderly had public health insurance (15 percent), the most common source of coverage was private insurance—usually purchased through an employment-based plan. However, 16.6 percent of the nonelderly population—or 36.3 million people—received neither private health insurance nor publicly financed health coverage.

Some uninsured individuals have limited access to basic health care services partly because they lack private health insurance and are ineligible for (or do not otherwise receive) publicly financed health care. Uninsured individuals may be forced to seek medical care for preventable ailments that could have been treated less expensively if they had received access to preventive health services. The cost of inefficient, uncompensated care is borne by all payers in the health care delivery system. The American Hospital Association estimated that hospitals provide $10 billion in uncompensated care annually.[2] Another study estimated that uninsured patients accounted for 11 percent of personal health care expenditures in 1988 ($32 billion), even though they had 37 percent fewer physician contacts and 69 percent fewer inpatient days.[3] The money spent annually on inappropriate care for uninsured patients may be more effectively spent by expanding access to basic health care services.

The March Current Population Survey (CPS) provides an important source of information about the economic and health insurance status of the U.S. population.[4] The following discussion and tables are based on the March 1992 CPS. This survey focuses primarily on the nonelderly population because this group receives health insurance coverage from a number of different sources, depending on income, employment status, and location, and because 96 percent of Americans aged 65 and over have Medicare coverage. This information can be useful in the analysis of legislative proposals designed to expand access to health care services.

Among the 36.3 million nonelderly Americans who did not have health insurance coverage in 1991, most were working adults (56.4 percent), while the remainder were children (26.3 percent) and nonworking adults (17.3 percent) (chart 1). The total number of uninsured under age 65 increased from 33.6 million in 1988 to 36.3 million in 1991.

Although some of this increase can be attributed to population growth, the percentage reporting no health insurance coverage has also increased from 15.9 percent to 16.6 percent between 1988 and 1991. However, there was no significant change in the percentage of the nonelderly population without health insurance between 1990 and 1991.

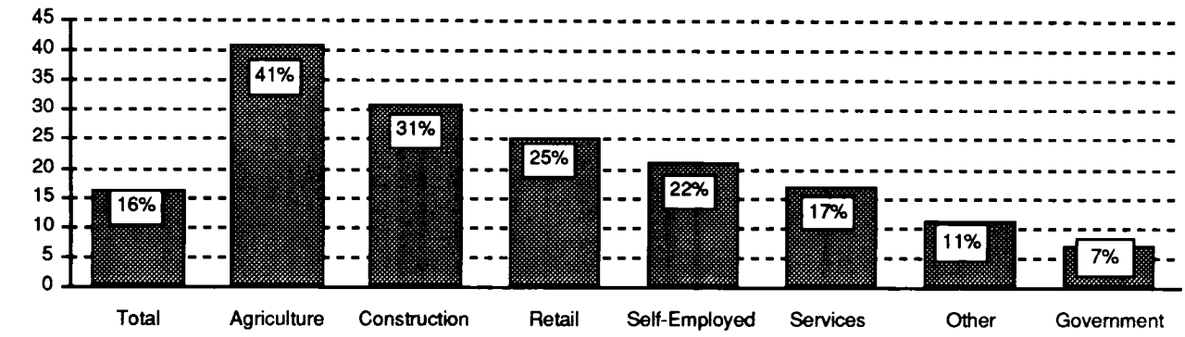
Employment Status

The most important determinant of health insurance coverage is employment. Nearly two-thirds of the nonelderly have employment-based coverage. Employers purchasing group health insurance are often able to obtain less expensive policies because insurance companies can spread the risk across a larger group of people. The nature of employment, the industry, and the size of the firm often determine the cost and extent of coverage. Workers in large firms are more likely to be covered than seasonal or part-time workers.

In 1991, 85 percent of the uninsured were working or living in a family headed by workers, primarily because most people live in families headed by workers (chart 2). More than 60 percent of the uninsured were in families headed by full-year workers with no unemployment; 53 percent were in families headed by full-year, full-time workers, and 8 percent lived in families headed by full-year, part-time workers. Even though only 12.6 percent of individuals in families headed by a full-time, full-year worker were not covered by insurance, they represent the largest segment of the uninsured (53 percent). However, individuals in families headed by a part-time worker were more likely to be uninsured than those headed by full-time workers. Individuals in families whose family head worked fewer than 17 hours per week were less likely to be uninsured (26 percent) than individuals in families whose family head worked between 17 hours and 34 hours per week (31 percent). This may be because publicly financed health coverage is less available to the latter group.

Industry—The majority of uninsured workers reported their industry of primary employment was retail trade, services, or manufacturing (chart 3)—industries that employ a majority of the work force. Workers most likely to be uninsured were either self-employed or working in agriculture, construction, retail sales, or services. Agricultural workers may be

Chart 3
Percentage Uninsured among Workers Aged 18–64, by Industry Group
Employee Benefit Research Institute Analysis of the March 1992 CPS



Note: Other industries include mining, transportation, communications, utilities, finance, insurance, real estate, manufacturing, and wholesale trade.

migratory and/or be paid low hourly wages. Construction industry workers may be employed on a contractual basis for a particular project. Because workers in these industries may not work consistently for the same employer, they are less likely to have employer-sponsored health insurance. Workers in the retail sales and service industries, which employ many part-time workers and experience rapid turnover, are often subject to waiting periods before becoming eligible for benefits.

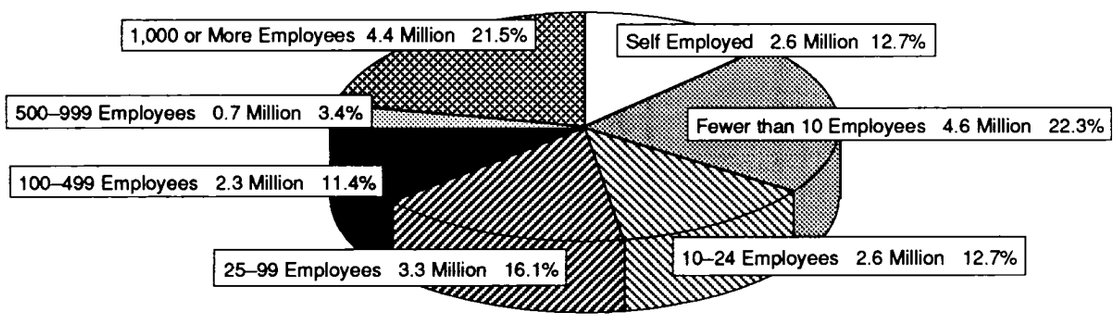
Firm Size—Nearly one-half of all uninsured workers were either self-employed or working in firms with fewer than 25 employees in 1991 (chart 4). Twenty-two percent of self-employed persons were uninsured, compared with 17 percent of all workers. Thirty-two percent of workers in firms with fewer than 10 employees were uninsured, compared with only 9 percent of workers in firms with 1,000 or more employees. Small employers often are unable to obtain reasonably priced health insurance for their employees because insurers generally charge them higher premiums due to the greater risk posed by a small group. In 1991, although only 27 percent of the nonelderly population lived in families whose head of household was self-employed or worked for a firm with fewer than 25 employees, this group accounted for 45 percent of the uninsured.

Income

The uninsured are concentrated disproportionately in low-income families. In 1991, 54 percent of the uninsured were in families with annual incomes under $20,000 (table 1). While 34 percent of all individuals in families with incomes of less than $5,000 were uninsured, only 11 percent of all individuals in families with incomes of $20,000 or more were uninsured. Families with incomes below the federal poverty level were more likely to be covered by publicly financed health programs or be uninsured than to be covered by private insurance. As income increases, the percentage of the population without health insurance and the percentage covered by publicly financed programs decrease, while the percentage covered by private health insurance increases. Because eligibility levels for Medicaid, the primary publicly financed health program for the nonelderly, are cut off at certain income levels (rather than being phased out),[5] the percentage uninsured among families with incomes below the poverty level was slightly less than that among families with incomes just above this level. This situation occurs because families with incomes just above the poverty level are less likely to be eligible for publicly financed insurance. At the same time, these people are also less likely than those with higher incomes to receive employer-sponsored health insurance.

Workers with low earnings are more likely to be uninsured than those with high earnings (chart 5). Thirty-one percent of workers with earnings below $10,000 were uninsured, compared with only 3 percent of workers with earnings of $50,000 or more. This is primarily because low-income workers tend to be employed in industries that are less likely to offer health insurance and/or have a weaker or temporary attachment to the work force. These workers may also be employed only part time or unemployed at times.

Chart 4
Workers Aged 18–64 without Health Insurance, by Firm Size,
Employee Benefit Research Institute Analysis of the March 1992 CPS



20.5 Million Uninsured Workers Aged 18–64

Table 1

Nonelderly Population with Selected Sources of Health Insurance, by Family Income, Employee Benefit Research Institute Analysis of the March 1992 CPS

Family Income	Total	Total Private	Employer Coverage			Other Private	Total Public	Medicaid	No Health Insurance Coverage
			Total	Direct	Indirect				
					(millions)				
Total	218.1	157.7	139.8	70.3	69.6	18.0	31.7	23.9	36.3
Under $5,000	12.9	2.1	0.8	0.4	0.4	1.2	6.7	6.4	4.4
$5,000–$9,999	15.9	3.3	2.0	1.3	0.7	1.3	8.1	7.4	5.1
$10,000–$14,999	16.1	6.7	5.2	3.2	2.0	1.4	4.6	3.9	5.6
$15,000–$19,999	15.7	9.1	7.6	4.4	3.2	1.4	2.7	2.1	4.7
$20,000–$29,999	32.6	23.8	21.0	11.4	9.6	2.9	3.5	2.3	6.6
$30,000–$39,999	30.6	25.9	23.6	11.4	12.2	2.3	1.8	0.8	3.8
$40,000–$49,999	26.4	23.5	21.7	10.0	11.6	1.9	1.4	0.4	2.4
$50,000 or More	67.9	63.4	57.9	28.2	29.7	5.5	2.9	0.6	3.8
					(percentage within coverage categories)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Under $5,000	5.9	1.3	0.6	0.5	0.6	6.9	21.3	27.0	12.0
$5,000–$9,999	7.3	2.1	1.4	1.8	1.0	7.3	25.5	31.1	14.0
$10,000–$14,999	7.4	4.2	3.8	4.5	2.9	8.0	14.4	16.2	15.4
$15,000–$19,999	7.2	5.7	5.5	6.3	4.6	7.9	8.4	8.6	12.8
$20,000–$29,999	15.0	15.1	15.0	16.2	13.8	16.1	11.2	9.5	18.2
$30,000–$39,999	14.0	16.4	16.9	16.3	17.5	12.6	5.8	3.2	10.5
$40,000–$49,999	12.1	14.9	15.5	14.3	16.7	10.5	4.3	1.9	6.6
$50,000 or More	31.1	40.2	41.4	40.1	42.7	30.7	9.1	2.6	10.5
					(percentage within income categories)				
Total	100.0%	72.3%	64.1%	32.2%	31.9%	8.2%	14.5%	11.0%	16.6%
Under $5,000	100.0	15.9	6.3	3.0	3.3	9.6	52.3	49.9	33.9
$5,000–$9,999	100.0	20.8	12.5	7.9	4.6	8.3	51.0	47.0	32.2
$10,000–$14,999	100.0	41.4	32.6	19.9	12.8	8.9	28.5	24.2	34.7
$15,000–$19,999	100.0	57.7	48.6	28.1	20.5	9.1	17.0	13.1	29.6
$20,000–$29,999	100.0	73.0	64.3	34.8	29.5	8.8	10.9	6.9	20.2
$30,000–$39,999	100.0	84.6	77.2	37.3	39.9	7.4	6.0	2.5	12.5
$40,000–$49,999	100.0	89.2	82.1	38.1	44.0	7.2	5.2	1.7	9.0
$50,000 or More	100.0	93.3	85.2	41.5	43.8	8.1	4.2	0.9	5.6

Note: Details may not add to totals because individuals may receive coverage from more than one source.

Family Type

Single individuals and individuals in single parent families were more likely to be uninsured than married couples either with or without children (chart 6). Married couples and two parent families may have higher levels of income and both adults may be employed, increasing their chances of receiving employment-based coverage and, if not covered through an employer, they may be more able to afford individually purchased private health insurance. Among poor and near-poor families (up to 124 percent of the poverty level), both married (46 percent) and single individuals (47 percent) without children were more likely to be uninsured than other family types. Families with children were less likely to be uninsured, at least in part because they were more likely to be receiving publicly financed health coverage. Sixty-seven percent of individuals in low income single parent families were covered by Medicaid in 1991, compared with only 27 percent and 31 percent of low income married couples and single individuals without children, respectively, and 37 percent of low income individuals in two parent families. Therefore, even though members of low-income two parent families were more likely to be covered by private health insurance than members of low-income single parent families (32 percent, compared with 15 percent), they were more likely to be uninsured (36 percent compared with 21 percent).

Chart 5

Percentage Uninsured among Workers Aged 18–64, by Total Earnings, Employee Benefit Research Institute Analysis of the March 1992 CPS

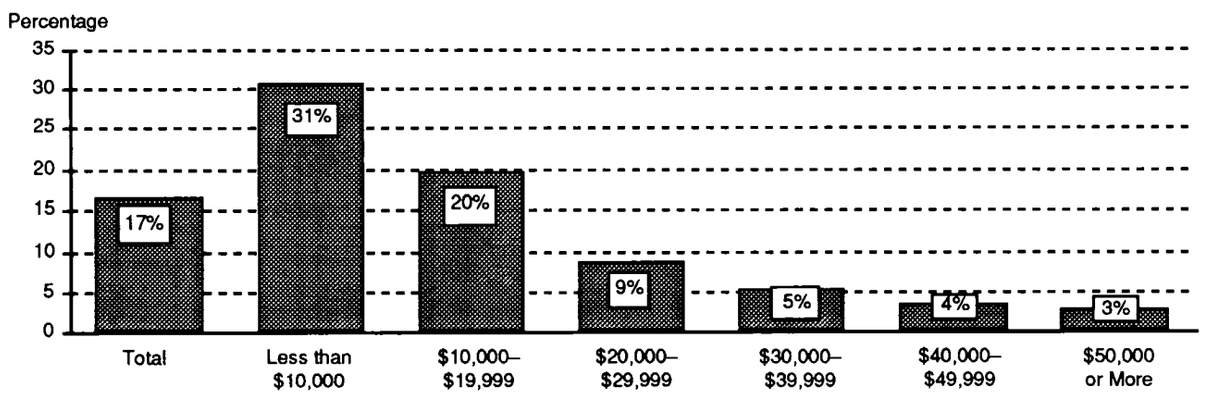
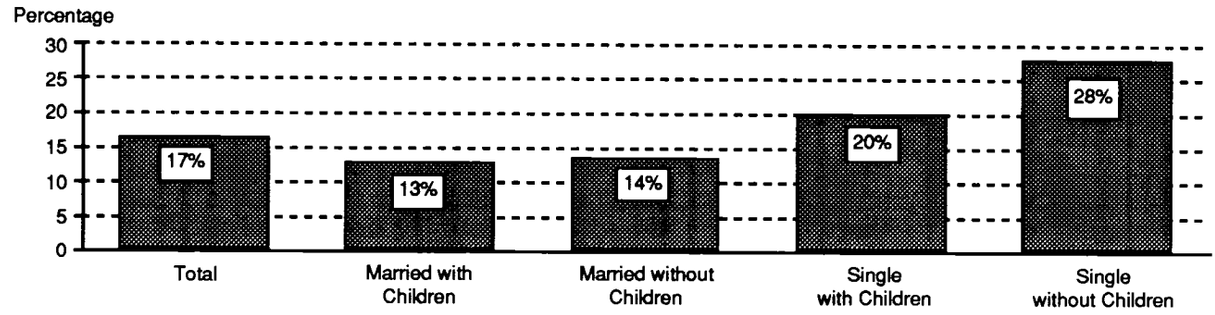


Chart 6
Percentage Uninsured among the Nonelderly Population, by Family Type,
Employee Benefit Research Institute Analysis of the March 1992 CPS



Other Demographic Characteristics

Sex and Age—Men were more likely to be uninsured than women in all age groups except between ages 55–64. Women were generally less likely than men to be covered directly by an employer health insurance plan but were more likely to receive employer coverage as dependents of other workers and publicly financed health coverage.

Individuals aged 45–64 were less likely to be uninsured (12 percent), and individuals aged 21–24 were more likely to be uninsured (30 percent) than those in all other age groups in 1991 (chart 7). The high proportion of young adults without health insurance may be because they are no longer covered by a family policy and have not established themselves as permanent members of the work force. In addition, many in this group may think that they do not need health insurance because they are young and healthy. Finally, young workers may be ineligible for an employer-sponsored plan because of waiting periods imposed prior to eligibility.

◆ Health Care Reform Proposals

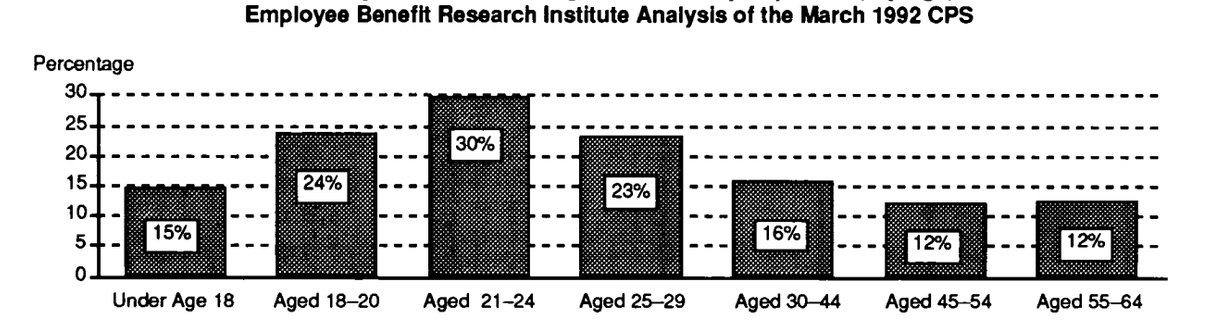
Congressional proposals for health care reform occupy almost every point along the spectrum from essentially fine tuning the health care delivery system by changing tax or regulatory policy to abandoning the private market and adopting a national health care delivery system. Recent policy attention has focused on proposals to limit the exclusion of employer contributions to health insurance and to mandate the provision of employer-sponsored coverage. EBRI has estimated the impact of such proposals.[6]

Tax-Based Reform

Several policymakers have recently suggested limiting the exclusion of employer contributions to health insurance from workers' taxable income. Advocates assume that if contributions are limited to a maximum dollar amount or to the average cost of a basic health plan in a geographic area, employers and employees would be more likely to choose cost-effective providers. Using the Tax Estimation and Analysis Model (TEAM), EBRI estimated the impact of capping tax-exempt employer contributions to health plans at $2,940 for family coverage and $1,080 for individual coverage. For those filers with employer-sponsored health benefits the imposition of a tax cap would be regressive in the sense that lower income filers would pay a larger percentage of their income than higher income filers toward the new tax.

Along with shifting the distribution of the tax burden, capping the tax exemption of employer contributions to qualified health plans would also generate additional federal revenue. EBRI's estimates assume no change in individual or employer behavior, although it is expected that significant behavioral change would occur as a result of changing the tax treatment of health benefits. These estimates should be considered as the maximum revenue that could be raised because they were produced assuming no change in behavior. According to our estimates, most of the tax revenue raised would come from middle and upper-middle income tax paypayers, with $8.3 billion coming from taxpayers with annual incomes of $20,000–$50,000 and $5.7 billion coming from taxpayers with annual incomes of $50,000–$100,000. This compares with $2.6 billion in revenue from taxpayers with annual incomes of less than $20,000 and $2.1 billion from taxpayers who earn more than $100,000 annually. EBRI also used TEAM to estimate the federal revenue raised as a result of an annual cap of $6,000 for family coverage and $2,400 for individual coverage. Most revenue would again be generated by taxing those with annual incomes between $20,000 and $50,000 ($2.8 billion), followed by taxpayers with annual income between $50,000 and $100,000 ($1.5 billion).

Chart 7
Percentage Uninsured among the Nonelderly Population, by Age,
Employee Benefit Research Institute Analysis of the March 1992 CPS



Employer Mandates

Proposals to require all employers to provide health benefits to their workers have been offered in Congress for over three decades. Renewed attention has focused on an employer mandate coupled with tax changes and insurance reforms. Employer mandates vary according to the employers that are required to participate, classes of employees covered, and length of time allowed to comply with provisions.

EBRI simulated the effects of an illustrative employer mandate, assuming that employers would be required to offer health benefits to all employees who worked more than 19 hours or 25 hours a week.

There are three critical assumptions that analysts have to make to estimate the impact of imposing a mandate: 1) how do wages and other benefits adjust when health insurance is required to be an element in total compensation; 2) how sensitive to changes in the costs of labor is employer demand for workers; and 3) how much would a mandated health plan cost. **EBRI assumed that wages and other benefits did not adjust in estimating the number of individuals who would lose their jobs as a consequence of a mandate that employers provide health benefits to their employees.**

Requiring all employers to provide health benefits to workers and their dependents would decrease the number of uninsured from 36 million to 10 million, according to EBRI estimates. Because many of the uninsured work for small firms, exempting employers with fewer than 25 employees would only reduce the number of uninsured to about 25 million. This analysis assumes that there are no changes in employment as a result of a mandate, even though health benefits represent a significant component of total compensation (10.9 percent of payroll among employers who offer health benefits[7]). Clearly, if a mandate were implemented without a transition period, that would allow other elements of total compensation (such as wages) to adjust, the cost of labor would increase substantially, possibly causing some job loss.

EBRI simulated changes in employment that would occur as a result of mandating that all employers offer health benefits (wages and other elements of total compensation were held constant). The sensitivity of employer demand for workers to changes in the price of labor is crucial in this simulation. The EBRI analysis used a range of estimates of this sensitivity based on economic literature.[8] It should be noted that other values supported by the economic literature could be cited that would increase or decrease the estimated employment effects by large amounts. The other crucial assumption used in this simulation was the costs of the mandated health benefits. Without specifying the actual component services that would be covered, separate EBRI simulations were conducted using different estimates of the average annual cost of health benefits per individual employee: $970, $1,450, and $2,430. The cost of each additional dependent was assumed to be 60 percent of the individual cost. Again, these estimates assume that wages and other benefits do not change as health benefits are added. Clearly, if wages adjust, fewer individuals would become unemployed as a result of a mandate.

EBRI's simulations estimated that between 200,000 and 1.2 million workers could become unemployed as a direct result of a mandate that employers provide health benefits to their employees. The higher estimates were the result of higher average costs of the mandated health plan and greater price sensitivity of the demand for labor.

The range in the estimates of the number of people who would lose their jobs as a result of mandates comes from the various combinations of benefit costs and sensitivity in the demand for labor to changes in costs. The estimate of 1.2 million for example can only be reached by assuming that employers are very sensitive to costs of labor and the health benefit package is very expensive. As is apparent, the estimates of job loss (and of the total costs of the policy) are extremely sensitive to the assumptions used in the simulation.

EBRI analysis also found that the cost of an employer mandate would be borne primarily by small employers and their employees. EBRI estimated that an illustrative employer mandate would increase spending by employers on employer-sponsored health benefits by $33 billion to $86 billion. The wide range between the estimates is related to assumptions about health plan costs. If employers with fewer than 25 employees were exempt from the mandate, spending would increase by $12 billion to $33 billion. Costs for employer-sponsored health benefits would also be redistributed. Workers who had previously been covered under another employer's plan would now be covered directly under their own employer's plan. For example, under a mandate with an average health plan cost of $1,450 per individual employee and no employer size exemptions, about $20 billion in costs would be redistributed from one employer to another. About 45 percent of these transferred costs ($9 billion) would be redistributed to small employers. If small employers were exempt from the mandate, the total costs redistributed among all employers would be only about $5 billion.

The ultimate aim of these simulations is to understand who will bear the costs of expanding health insurance coverage through mandating that employers provide it to their employees. Other analysts have estimated a much smaller increase in the number of individuals who may lose their jobs because of an employer mandate by assuming the wages and other benefits would fall enough to fully account for the cost of the mandated plan. Regardless of what assumptions are used, it is clear that the recipient of the coverage will inevitably bear the costs of the coverage, either through loss of his or her job or lower wages and other benefits. Arguments have been advanced on both sides of the issue of whether this is a fair, equitable, or efficient result.

The question of whether uninsured workers and their families would be better off if health insurance were extended to them under a mandate centers on the issue of whether they are uninsured by choice. Do workers select jobs that do not offer health benefits in order to receive higher levels of cash compensation or other benefits? If employees are choosing a total compensation package that does not include health benefits, any measure that forces them to accept a package with health benefits will make them worse off.

However, society may benefit by forcing individuals to purchase health insurance. Individuals who choose to not purchase health benefits are gambling that they will not need health care services. They may make that bet knowing

that care will be available to them in the case of a catastrophic event. Thus, society may bear at least a part of the risk that the individual chose not to insure against.

An employer mandate is essentially a payroll tax, although the burden of that tax is not distributed equally across all employees, employers, or consumers. Some of the costs of mandated health benefits would be passed on to employees in the form of lower wages, lower levels of other noncash benefits, or unemployment. Low-income workers would have less opportunity to trade wages for health benefits and would be more likely to experience the effects of an employer mandate in the form of unemployment. Some of the costs might be passed on to consumers in the form of higher prices. The remainder of the costs of a mandate would be borne by the investors and owners of the firms subject to the mandate. The distribution of this burden would vary by industry, region, firm size, and ownership type. The ultimate incidence of this tax will be determined by the market for health insurance.

◆ Conclusions

The majority of Americans consider health care to be a right. Although most prefer care with no cost, they are willing to share some costs explicitly and more costs on a hidden basis. Americans want "reform", but only reform that means more attentive providers, more accessibility, no risk of forfeiture, and lower costs.

This testimony provides information on the characteristics of Americans with and without health insurance that should be useful in analyzing health care reform proposals as the new administration prepares its agenda for health care reform. More detailed data can be found in EBRI's January 1993 *Issue Brief*, "Sources of Health Insurance and Characteristics of the Uninsured," which we have provided to the Subcommittee.

EBRI's estimates of tax changes and employer mandates attempt to draw out some of the tradeoffs implicit in health care reform. As this testimony illustrates, there are limits in determining the effects of these proposals. Important details of many of the proposals have not been developed. Moreover, the literature on important questions such as the effects of tax changes and increased labor costs is often incomplete or contradictory. The greater the amount of change proposed by a reform proposal the greater the uncertainty of estimates regarding costs and coverage.

◆ Endnotes

[1]These data are taken primarily from an EBRI *Special Report/ Issue Brief*, "Sources of Health Insurance and Characteristics of the Uninsured," January 1993.

[2] American Hospital Association. Statement of the American Hospital Association Before the Committee on Ways and Means of the U.S. Congress, House of Representatives, on National Health Care Reform. October 10, 1991: Summary. Washington, DC: American Hospital Association, 1991.

[3] Lewin/ICF. ***The Health Care Financing System and the Uninsured.*** Prepared for U.S. Department of Health and Human Services, Health Care Financing Administration. Washington, DC: Lewin/ICF, 1990.

[4]The March CPS questions individuals about their health insurance coverage throughout the preceding calendar year. Respondents to the 1992 survey were instructed to provide information about their health insurance coverage during 1991. Assuming accurate responses were given, the uninsured should include only those individuals who were without health insurance for the entire 12 months. However, a comparison of the results of the March 1990 survey with the Survey of Income and Program Participation has led some researchers to believe that many respondents actually answer the health insurance questions with reference to either a particular point in time or to some period of time less than the full year.

[5]Medicaid eligibility levels are set by individual states and vary from 13 percent of the federal poverty rate in Alabama to 77 percent in Alaska. About two-thirds of the states have higher income eligibility thresholds for "medically needy" persons. All states are required to provide Medicaid coverage to pregnant women and children up to age 6 if their income is less than 133 percent of the federal poverty level. In addition, states must cover children born after September 30, 1983, in families with income below the poverty level.

6 A more complete examination of EBRI's analysis of various health care reform proposals can be found in EBRI's *Issue Brief*, "Health Care Reform: Tradeoffs and Implications," April 1992.

[7]A. Foster Higgins & Co., Inc. ***Health Care Benefits Survey, Report 1: Indemnity Plans.*** New York: A. Foster Higgins & Co., Inc. 1992.

[8]Hamermesh, Daniel S. "The Demand for Labor in the Long Run." In ***Handbook of Labor Economics.*** Vol. 1. New York: Elsevier Science Publishers, 1986.